

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICAID
Proactive Safeguards**



**JUNE GIBBS BROWN
Inspector General**

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OEI's Chicago Regional Office prepared this report under the direction of William C. Moran, Regional Inspector General and Natalie A. Coen, Deputy Regional Inspector General. Principal OEI staff included:

REGION

John M. Traczyk, *Project Leader*

HEADQUARTERS

Jennifer Antico, *Program Specialist*

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EXECUTIVE SUMMARY

PURPOSE

This is the first of three reports describing Medicaid program safeguards. This report discusses proactive safeguards. The second report discusses claim processing safeguards and the third report discusses post payment safeguards.

This report is intended to provide information about and increase awareness of Medicaid proactive safeguards. Proactive safeguards anticipate problems and attempt to thwart, or ward off, wrong doers. They occur before a patient receives services and before a claim for services is generated for payment.

PROACTIVE SAFEGUARDS

Provider/Vendor Enrollment (including revised enrollment forms, onsite visits, background checks and fingerprinting, surety bonds and improved verification procedures) makes it more difficult for unqualified and unscrupulous providers to gain access to Medicaid systems.

Periodic Provider Re-enrollment helps screen out inactive providers and providers not engaged in legitimate businesses.

Provider Number Termination reduces the likelihood that they will be misused by unscrupulous persons to defraud Medicaid.

Provider, Patient and Employee Education should be the first line of defense against Medicaid fraud and abuse.

Prior Authorization is used by States to control problematic providers and abused medical services.

Certificates of Medical Necessity are frequently used by States to obtain information about the medical need for specific services, supplies and equipment.

Prime Vendor Contracts reduce the price of products and services by permitting a private business entity to function as the primary source for specific services or products.

OPPORTUNITIES FOR IMPROVEMENT

Based on our prior studies and information gathered during this study, we encourage States to consider the following opportunities for improving program safeguards:

- ▶ **Target high risk providers for extensive application review and verification.** Extensive reviews of all enrollment applications may not be cost effective; however, it appears that extensive reviews of specific providers and improved information verification techniques deter unscrupulous persons from obtaining a provider number.

- ▶ **Expand the use of local field offices to conduct onsite visits to verify the legitimacy of problematic providers.** Onsite visits appear helpful in establishing the legitimacy of high risk provider number applicants. Some States have increased the number of onsite visits and controlled the costs associated with onsite visits by using their local field offices.
- ▶ **Conduct more frequent and better education of providers concerning their obligation to protect their provider number(s) from unauthorized use and the need to notify Medicaid when their employment relationships with clinics and other providers terminates.** Evidence suggest that many physicians do not adequately protect their provider numbers. Unscrupulous persons circumvent provider enrollment safeguards by stealing a legitimate provider's billing number or purchasing the billing number of a legitimate provider. Some physicians are totally unaware that billing number information they have shared with former and potential employers has been used to defraud Medicaid.
- ▶ **Strengthen Federal and State laws to hold physicians and other Medicaid providers financially and criminally liable for participating in any deception that allows others to use their credentials and business to defraud or cause financial harm to a State Medicaid program.** We believe that government programs need to address the vulnerability in their system safeguards stemming from physicians who permit others to use their identity to circumvent program safeguards or who permit the use of their professional licenses and places of business as a front to deceive Medicaid.
- ▶ **Identify and register all clearinghouses and third-party billers and improve safeguards to ensure that electronic claims are accepted only from authorized sites and terminals.** Today's Medicaid systems do not ensure that claims originating from billing agencies have been properly authorized by the physician under whose name claims are submitted. Most Medicaid programs cannot identify billing companies that submit claims nor can they determine which physicians use which billing companies.
- ▶ **Centralize responsibility for, and improve, employee fraud and abuse awareness training.** With some exceptions, it appears that fraud and abuse awareness training may be too fragmented to be effective.

We intend to do additional in depth studies on proactive safeguards used by States.

AGENCY COMMENTS

The HCFA believes that the opportunities for improvement described in this report provide valuable information that will be shared with the State Medicaid programs.

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INTRODUCTION

PURPOSE

To provide information about and increase awareness of Medicaid Proactive safeguards.

BACKGROUND

Medicaid is a health insurance program for certain low income and needy people. Within Federal limits, each State decides eligibility, benefit coverage, administrative practices, reimbursement and operational resource requirements. About 70 cents of every Medicaid dollar goes to institutional providers (hospitals, nursing homes). Thirty cents pays for non-institutional services (physician services, laboratory and radiology). Federal law requires States to pay for services provided by certain institutional providers and non-institutional providers. States may elect to offer additional services such as dental care, podiatric care and prescription drugs just to name a few.

The Health Care Financing Administration (HCFA) is responsible for administering Federal matching funds to the States and for legislation and regulations affecting Title XIX (commonly referred to as the Medicaid program). The HCFA also provides guidelines, technical assistance and periodic assessments of State programs. More than 36 million recipients are enrolled in Medicaid. In 1991, 90 percent of these recipients were enrolled in fee-for-service (FFS) programs. By 1998, the number of recipients in FFS had decreased to 46 percent and enrollment in managed care plans increased to nearly 54 percent. Nearly \$169 billion was spent by the Federal Government and the States on Medicaid benefits in Fiscal Year 1998.

States are required by legislation to make every effort to eliminate waste and illegitimate program expenditures. States are also required to develop payment safeguards designed to protect their Medicaid funds from unscrupulous and fraudulent providers. Most States also have a Medicaid Fraud Control Unit to investigate allegations of fraud and abuse.

METHODOLOGY

We visited or interviewed over the telephone agency(ies) responsible for administering the Medicaid program in the following eight States:

California	Florida	Illinois
Louisiana	Maryland	Oregon
Pennsylvania	Texas	

These States were selected for site visits because they account for nearly half of all Medicaid expenditures. They were also chosen for their geographic location. Our site visits were conducted during the spring of 1999. During our visits, we discussed program safeguards used by the State's Medicaid program. We spoke to State Agency officials and, when appropriate, to State subcontractors.

We did not discuss payment safeguards used by managed care organizations and State pharmacy programs. Our discussions focused on Medicaid fee-for-service program safeguards. We have not attempted to assess the effectiveness of each safeguard.

The primary purpose of this report was to compile a catalog of program safeguards used by eight State Medicaid programs. Every effort was made to prepare a comprehensive and complete list. Undoubtably, there will be some disagreement as to what constitutes a program safeguard. Moreover, States, their subcontractors and others may have information about other safeguard measures not mentioned in this report.

This is the first of three reports on Medicaid safeguards. This report discusses proactive safeguards. Proactive safeguards are those measures taken to prevent fraud, abuse and waste before a claim is ever submitted for payment. The second report discusses claim processing safeguards and the final report discusses post payment safeguards.

PROACTIVE SAFEGUARDS

Proactive safeguards are those preventive measures used by States to reduce their Medicaid program's exposure to fraud and abuse. These measures anticipate problems and attempt to thwart, or ward off, wrong doers. They occur before a patient receives services and before a claim for services is generated for payment. This report describes the proactive safeguards we identified in the eight States we visited.

Provider/Vendor Enrollment

Provider enrollment is the first line of defense in the fight against fraud and abuse. Keeping unqualified and unscrupulous providers from gaining access to Medicaid systems not only protects patients but also lowers administrative costs and protects program assets.

Medicaid State Agencies, or their subcontractors, assign provider numbers to qualified physicians and other suppliers who furnish services and supplies to Medicaid patients. These numbers are required for claims processing, for accounting purposes and for administrative functions. To obtain a provider number, every physician, hospital and medical supplier must complete an enrollment application.

Application Forms

Florida, Oregon and Texas said that they had developed new enrollment application forms. These new applications are designed to solicit additional information to aid the States in determining whether an applicant for a provider number is qualified to provide services to patients and a legitimate business entity.

The applications used by States vary in length and complexity. All solicit information about applicants, their tax payer identification (Employer Identification Number or Social Security Number), the nature of their business, the location of their business and licensing information. Additional information is often requested from providers that States believe pose the greatest risk to their Medicaid program. Most of the States require copies of business and professional licenses and taxpayer identification. Some ask for proof of insurance, copies of drivers licenses, proof of vehicle registration, proof of training or professional association certification.

Most provider enrollment applications are subjected to desk reviews. All of our States verify business and professional licenses of applicants by contacting the license issuing agency. States also look for applicants who may have been excluded from participating in Medicare or any State Medicaid program. In Illinois, Florida, Oregon and Texas, applications that appear to contain discrepancies or false information are referred to program integrity or the Medicaid Fraud Control Unit for investigation.

Onsite Visits

Florida and Louisiana routinely conduct onsite visits to determine whether applicants for provider numbers are, in fact, operating a legitimate business. California and Illinois limit onsite visits to new providers who they believe pose the greatest risk to their Medicaid program. These States do not visit hospitals, nursing homes and other facilities that must pass routine Federal or State onsite inspections. They focus their efforts on durable medical equipment companies, diagnostic service providers and other high risk provider groups.

Information received from the States of Florida and Texas demonstrate the sentinel effect of onsite visits. In 1 month, Florida received about 85 new provider applications from Dade county. Onsite visits revealed that none of these applications were legitimate, and all were denied. In Texas, the Medicaid State Agency made visits to the business location(s) of new providers during a time period specified by legislation. The number of new provider applicants during the study period declined by more than 50 percent. After the study period ended, the number of applications returned to pre-study levels. Onsite visits, to providers who applied during the study period, revealed that all were legitimate businesses. The Texas State Agency believes that bogus businesses knew they would be visited and delayed seeking a provider number until the test period ended.

Some States use local welfare field offices to conduct onsite visits. Florida and Louisiana use local field offices and out stationed Medicaid staff to ensure that every new provider is visited before a provider number is issued. The Medicaid State Agency provides guidance on how to conduct each onsite visit but the actual visits are conducted by existing field office staff.

California, Illinois, Maryland, Oregon and Texas do not conduct routine visits to new providers. They claim that such visits are not cost effective and that they have insufficient staff to undertake this endeavor. Moreover, lawsuits in California have put pressure on that State to stop delaying and expedite the issuance of Medicaid provider numbers.

Background Checks And Fingerprinting

The Florida Medicaid program conducts background investigations and fingerprints nearly all applicants requesting a new provider number. Florida also conducts background investigations and fingerprints providers re-enrolling in their Medicaid program. Florida uses fingerprints to verify the identity of applicants desiring to obtain a Medicaid provider number. Of the 60,000 providers in the Florida Medicaid program, 52,000 have undergone a background investigation and been fingerprinted. Of 52,000 background checks completed, nearly 1,600 providers were found to have a criminal record.

Florida law allows the State Agency to deny enrollment in their Medicaid program to any provider¹:

- ▶ convicted of character-related felonies;
- ▶ found to have made false representations or omitted any material fact;
- ▶ excluded, suspended, terminated or involuntary withdrew from *any* State Medicaid program or the Medicare program;
- ▶ convicted of obstructing or interfering in the conduct of a criminal investigation;
- ▶ found by licensing, certifying or professional standards board or agency to have violated the standards or conditions relating to licensure, certification or quality of care;
- ▶ Failing to pay fines or overpayments assessed by the Medicaid program.

Florida works with the State's Department of Law Enforcement to conduct background checks and fingerprint re-enrolling and newly enrolling providers. All persons with 5 or more percent ownership in a business applying for a Medicaid provider number are required to be fingerprinted. In high risk counties (Dade and Broward), all re-enrolling and newly enrolling providers must be fingerprinted. Non-physician applicants must identify their referring physicians. These referring physicians must have a completed background investigation, have been fingerprinted and be currently enrolled in the Florida Medicaid program. The cost of screening applicants and re-enrolling providers is \$15 per person. This cost is paid by the applicant. The California Medi-Cal program is also considering conducting background checks and fingerprinting new and re-enrolling Medicaid providers.

Surety Bonds

States are using surety bonds to address vulnerabilities in their Medicaid program. Surety bonds provide a financial incentive designed to discourage unscrupulous providers from enrolling in a State's Medicaid program. They help to ensure that providers have the capacity to provide services and they provide financial protection against provider fraud.

Florida and Louisiana can require high risk providers to post a surety bond. In Florida, a \$50,000 surety bond is required of all new durable medical equipment providers, private transportation companies, non-physician owned clinics, independent laboratories and home health agencies. A surety bond is also required of *all* providers doing business in Dade and Broward counties, and of all new providers in the remainder of the State.

In Louisiana providers whose behavior is unacceptable can be required to re-enroll and to post a bond. Louisiana "*sanction bonds*" and Florida's surety bonds are intended to protect their Medicaid programs from potential financial losses. Bonding also adds

¹ Or any officer, agent, managing employee, affiliated person, partner or shareholder having ownership interest of 5 percent or more.

another level of provider scrutiny. Most bonding companies conduct their own investigations to verify applicant information before agreeing to bond an individual or company.

Third Party Verification

All of the States we visited verify professional licenses of applicants with the appropriate State licensing board(s). Some States verify business licenses by contacting State, county and city business licensing departments. Some (CA & TX) verify vehicle registration or applicant drivers licenses. California solicits the names of manufacturers and suppliers having a business relationship with an applicant for a Medicaid provider number. The provider's manufacturers and suppliers are then contacted to verify application information. The Florida State Agency compares information provided to the bonding company with information supplied to them during provider enrollment.

Periodic Provider Re-enrollment

Florida, Illinois, Louisiana and Texas have taken steps to re-enroll some or all of their Medicaid providers. However, the actual process for doing so is fragmented among the various State Agencies. In some States, the department responsible for mental health workers and facilities would handle worker and facility enrollment or re-enrollment. Pharmacies would be handled by another State Agency and so forth.

Some States believe that provider re-enrollment is resource intensive, too costly and of questionable cost benefit. The last time Oregon re-enrolled providers was in 1982. California and Pennsylvania have never re-enrolled any of their providers. States like the idea of periodic re-enrollment but claim they lack staff, resources and legislative support for such an undertaking.

Florida has re-enrolled all of its Medicaid providers. When Florida Medicaid asked all of its Medicaid providers to update their provider applications, numerous letters were returned as undeliverable. Florida's re-enrollment project reduced the number of durable medical equipment providers from 4,385 to 1,500. The number of home health and transportation providers fell by nearly half after re-enrollment. Overall, Florida has reduced the number of Medicaid provider numbers from nearly 83,000 in 1995, to approximately 60,000 in 1999. Florida plans to re-enroll one-third of its providers every 3 years.

Illinois has begun re-enrolling the providers in their Medicaid program. Unlike Florida, which asked all providers to re-enroll, Illinois has decided to re-enroll providers by speciality. The first specialist to be re-enrolled in the Illinois Medicaid program were dentists. Prior to re-enrollment there were more than 3,000 provider numbers assigned to dentists. After re-enrollment, the number of providers fell to about 700.

Louisiana re-enrolled all non-emergency medical transportation (NEMT) providers when they redesigned their program. They have also re-enrolled chiropractors, mental health providers, rehabilitation providers and case management providers. Like Illinois, Louisiana experienced a significant drop in the number of providers.

Efforts in Texas to re-enroll Medicaid providers are currently underway. All Texas providers were required to re-enroll by September 1, 1999 or lose their eligibility to bill that State's Medicaid program. The Texas effort is aimed at ensuring that all the providers in their system are legitimate businesses.

Provider Number Termination

Experts and law enforcement officials believe that poor controls over provider numbers that have been issued may be a vulnerability in Medicaid program safeguards. Information by States indicates that there are people who defrauded Medicaid using inactive provider numbers. States also told us about people who obtained multiple provider numbers and then used them to avoid Medicaid payment safeguards and to defraud Medicaid. One State mention how clinics and other providers have used the provider numbers of retired or former employees to defraud Medicaid.

Florida has uncovered clinics that obtained improper Medicaid payments using the un-terminated provider numbers of physicians who were no longer affiliated with the clinic or who had retired from active practice. Florida sent letters to physicians asking them to verify the clinics at which they had worked and their dates of employment. The physician responses showed that some clinics continued to use a physician's provider number(s) after the physician had left the clinic. Overall, more than 100 clinics and physicians were terminated from the Florida Medicaid program for irregular billing practices.

Florida, Louisiana and Texas have found physicians who sold their provider numbers to persons who then used them to defraud Medicaid. All of these States plan to take action against physicians who participated in schemes to defraud Medicaid. Florida has referred nearly 150 physicians to the State Medicaid Fraud Control Unit for investigation and possible referral to the Justice Department for criminal, civil and administrative prosecution. The State of Florida contends that these physicians established bogus relationships with clinics and other health care businesses that enabled others to defraud the State Medicaid program.

All of the States we visited have provider number termination policies. However, some States appear reluctant to remove unused provider numbers from their system. In some States, removing a provider number is a lengthy process. All of the States we visited claim they can identify providers with no claims activity over a specified period of time. All move their inactive provider numbers to a suspense file for a specified period of time.

If the provider submits a single claim after their number is moved to the suspense file, the number will be re-activated without the need for a new provider enrollment application. In most cases, the actual removal of a provider number from Medicaid systems occurs after 3 years of no claim activity; however, in some States the actual removal of a provider number can take 5 years or more. Providers whose numbers have been terminated must complete a new provider application and get a new number.

Provider, Patient and Employee Education

Health care experts believe that teaching providers, patients and Medicaid employees about fraud and abuse can have a sentinel effect on provider behavior. Provider, patient and employee education increases awareness as to what is not acceptable billing. It also increases the likelihood that potentially fraudulent and abusive practices will be reported for in-depth investigation.

Provider Education

The eight States we visited furnish provider handbooks to all of their Medicaid providers. Handbooks help providers understand the laws, regulations and policies that govern their claims and claim payment. They provide information about what is, or is not, covered and how to bill correctly. Providers are notified of policy changes by letter, on remittance advices, in bulletins and at sites on the Internet.

States also conduct training at medical conferences, health fairs and other professional settings. Medicaid staff often make presentations on topics of interest to providers and respond to provider questions about coverage, payment and other programmatic issues.

States also make visits to provider offices to help them correct problems with their billing or to explain coverage and payment policies. Onsite visits are also used to warn providers about unacceptable billing practices found during claims processing or post payment reviews. This study did not determine the quality and quantity of Medicaid provider education efforts. Little is known as to how much emphasis Medicaid places on provider awareness of fraud and abuse and the consequences of engaging in such activity.

Patient Education

State efforts to increase Medicaid patient awareness of fraud and abuse vary from State to State. One State, that we visited, felt that patients were not a good source for identifying potentially fraudulent and abusive providers. Other States felt they had achieved some degree of success in combating fraud and abuse with their patient education programs. Despite mixed feelings as to the effectiveness of their patient education programs, all eight States in our sample routinely participate in health fairs and other venues that target patients.

Employee Education

Six of the eight States told us that they had conducted training to help their employees spot and report possible fraud and abuse. One of these States told us that they had conducted training of employees in the claims processing division. They assume that other Medicaid operational and policy divisions (i.e., Mental Health Department, Pharmacy Program) have also conducted training to increase employee awareness of potential fraud and abuse situations. In Florida, Louisiana and Texas the State Medicaid Agency has centralized responsibility for all fraud and abuse training given to *all* employees involved in administering their Medicaid program. The Florida State Agency has also developed an employee handbook to help their employees spot potential fraud and abuse. In these States, employee training about fraud and abuse is centralized.

One State felt that an organized educational effort was not needed because their employees knew how to spot fraud and abuse and that they would refer any questionable conduct to their supervisor. Eventually, the problem would find its way to the State's program integrity unit.

Prior Authorization

All of the States we visited have identified medical services that require prior authorization. All of the States we visited use prior authorization to control problematic providers and abused medical services. Prior authorization protect patients from unnecessary services and procedures. The States believe that prior authorization has a deterrent effective.

Most States that we visited, require providers to obtain prior authorization for acute hospital admissions and psychiatric hospital admissions. Responsibility for authorizing most services is centralized in the State Medicaid Agency or their contractor(s). In Louisiana, Louisiana State University, School of Dentistry is responsible for the prior authorization of dental services for that States's Medicaid program. In Illinois, the State Medicaid program contracts with a private dental insurer for prior authorization services. An outside agency handles hospital admissions, transportation, home health and some ancillary services in Oregon.

Services Requiring Prior Authorization

- Acute and Psychiatric Hospital Admissions
- Ambulatory Surgical Center Services
- Dental services
- Home Health Services
- Hospital Outpatient Services
- Incontinent Supplies
- Mental Health Services
- Non-Emergency Medical Transportation
- Rehabilitation & Therapy Services
- Same Day Services
- Transplants

Some Medicaid services are authorized by local field office personnel, who use State guidelines when deciding whether or not to approve medical services. Local office medical workers have responsibility for authorizing most non-emergency medical transportation services provided to aged and disabled persons and to persons receiving general assistance. Some local field offices also authorize some other medical services such as personal care attendants.

Seven States in our sample have increased their use of prior authorization. California uses prior authorization to control utilization of incontinent supplies and other abused services and supplies. California has not measured the effect of its prior authorization program but estimates that without the sentinel effect of prior authorization their payments for services would be about 20 percent greater than current expenditure levels.

Louisiana claims that prior authorization of mental hospital and acute hospital admissions has saved that State more than \$100 million. The State reviews diagnostic information, anticipated services and clinical indicators of severity of illness when deciding whether to approve or deny a hospital admission. This same information is used to determine the number of inpatient days the State Medicaid program will authorize and pay. Before prior authorization, Louisiana's spending on inpatient mental health services had risen from \$5 million to \$36 million annually. After the State re-engineered their policies and coverage guidelines and added prior authorization requirements, payments fell. Today, Louisiana payments for inpatient mental health services have been reduced to about \$10 million per year.

Prior authorization of and changes to Louisiana's non-emergency transportation benefit has resulted in annual payment levels falling from \$60 million per year to \$8 million yearly. When Texas instituted prior authorization for transportation services, they saw a tremendous drop in the number of non-emergency medical transportation claims and payments. Annual payments, for transporting dialysis and cancer patients to and from therapy, declined from \$4 million to \$2 million.

All of the States acknowledge that prior authorization has an unmeasurable deterrent effect. What States can measure is the number of prior authorization requests that are denied. While this number is small (on average, less than 5 percent), the savings from services denied are significant. In 1998, Pennsylvania Medicaid received more than 174,000 prior authorization requests. About 5,200 or 3 percent of the 174,000 prior authorization requests were denied. These denials saved the Pennsylvania Medicaid program more than \$25 million in 1998. Pennsylvania has seen no increase or decrease in their Medicaid program expenditures over the last 3 years. The State attributes this to their prior authorization and pre-certification policies.

Oregon questions whether prior authorization is an effective tool or just "rubber stamping." Providers are usually given Medicaid guidelines and other information that describes the specific criteria that must be met to obtain prior authorization. This information may help ensure approval of medical services. While this may be true, other States report that they address this vulnerability during their post payment reviews. If the

patient medical records do not support the level of service authorized by the State, the provider will be asked to refund any overpayment.

Oregon has reduced the number of services requiring prior authorization. The Oregon Medicaid program found that prior authorization of some services was not cost effective and merely made providers jump through hoops to get authorization. Oregon has removed some medical services, some supplies and small payment items from prior authorization. Oregon found that it was not cost effective to prior authorize small payment items. While Oregon has cut the number of services requiring prior authorization they have also developed stricter criteria for approving services and supplies still requiring prior authorization.

Second Opinion

Scientific evidence exists that suggests that some medical procedures and drugs are over used by the medical community. Despite this, most State Medicaid programs do not require patients to have a second opinion before undergoing over used and potentially medically unnecessary medical procedures.

Pennsylvania recently terminated their second opinion program because they felt it had outlived its usefulness as more and more patients were enrolled in managed care. Pennsylvania believes that it is up to managed care organizations to decide whether or not they want a second opinion program.

Nearly all of the States in our sample have abandoned mandatory second opinion safeguards because they found them ineffective and costly to administer. State second opinion programs allowed the patient's physician to suggest other providers that the patient might contact for a second opinion. Patients were also permitted to choose, on their own, a physician for a second opinion. Several States mentioned that they still pay for a second medical opinion if requested by the patient.

Illinois, California and some private sector insurance plans have experienced success with their second opinion programs. In Illinois and California, patients about to receive certain dental services are re-examined by dentists affiliated with the State's dental contractor. Both claim that their dental second opinion program has saved money and prevented patients from undergoing unnecessary procedures. These States believe that the effectiveness of their second

Partial List of Overused Services

Bunionectomy	Carotid endarterectomy
Cataract surgery,	Coronary artery bypass
except congenital	Coronary angioplasty
Hemorrhoidectomy	Hip replacement
Hysterectomy	Knee surgery
Mastectomy	Myringotomy with tubes
Prostatectomy	Spinal and vertebral
	surgery
Submucosa resection	Tonsillectomy with or
Varicose vein stripping	without adenoidectomy

opinion program is due to their contracts with independent, unbiased physicians who have been hired to provide the second opinion.

Certificates of Medical Necessity

All of the States we visited require that physicians certify the medical need for specific services, supplies and equipment. Certificates of medical necessity (CMNs) are attestations by physicians stating that they have ordered the services or supplies and that the services and supplies ordered are medically necessary for the care and treatment of the patient. The CMN is submitted to Medicaid along with the claim for reimbursement. Processing of claims for services and supplies requiring CMNs is usually interrupted until the CMNs and claims are manually reviewed. Additional information is obtained from providers whose CMNs are incomplete or contain discrepancies that prevent further processing.

Prime Vendor Contracts

Florida, Maryland, Oregon and Texas use prime vendors to provide specific services to patients. Illinois is also considering using prime vendor contracts. Prime Vendor contracts permit a designated private business to function as the primary source for specific services or products produced or provided by other suppliers. The prime vendor is responsible for delivery of specific products and services to Medicaid patients.

New York has passed legislation requiring the State Medicaid program to seek competitive bids for various durable medical equipment (DME) services. New York has issued Requests for Proposals (RFPs) for diapers and is developing another for diabetic supplies and high-compression stockings.

Maryland uses prime vendors to provide non-emergency transportation services (NEMT). Local welfare offices put out requests for proposals (RFPs) and obtain bids. One, or more bidders, are then awarded contracts to provide all NEMT services within a particular geographic area. All authorized NEMT services are provided by the entity holding the contract.

Oregon uses brokers to manage Medicaid patient transportation needs in the Tri-county area that includes Portland. The State Medicaid program pays brokers a fixed rate. The broker arranges the transportation services a patient needs and pays the provider that actually transported the patient. The difference between the State Medicaid payment and the broker's expenses is the broker's profit or loss.

In Texas, problems identified in the State Controller's study of Medicaid payment errors lead to that States limiting the number of NEMT providers. Only services authorized and provided by contracted providers or service companies are payable under the Texas Medicaid program. Illinois is considering a similar plan.

OPPORTUNITIES FOR IMPROVEMENT

Each of the States we visited has taken a different approach to keep unqualified and unscrupulous persons from gaining access to their Medicaid systems. Every State should have aggressive proactive safeguards. Based on our prior studies and information gathered during this study, we would encourage States to consider the following opportunities for improvement:

Target high risk providers for extensive application review and verification.

Today's provider enrollment applications solicit more information than a decade ago. Verifying information provided on them can be improved by prioritizing applicants based on risk. Applicants considered high risk would undergo more extensive application development to verify information.

Some States have reduced their vulnerability to fraud and abuse by improving the way that they verify information provided by applicants. As some States have discovered, reliance on application information may be a vulnerability in their provider enrollment process. Application information submitted by some providers has been found to be false.

States could improve their third party verification by independently locating and contacting an applicant's manufacturers, suppliers, supervising physician and other references. Our experience has shown that relying solely on applicant supplied information (i.e., names, telephone numbers, etc.) is a vulnerability.² Independently verifying reference names, addresses and telephone numbers would help ensure that the references provided by an applicant are, in themselves, legitimate businesses or persons.

Expand the use of local field offices to conduct onsite visits to verify the legitimacy of problematic providers.

Onsite visits appear helpful in establishing the legitimacy of some provider number applicants. Information from States that make onsite visits demonstrates that onsite visits are an effective proactive safeguard. Onsite visits appear to deter unscrupulous persons from obtaining a provider number.

Conduct more frequent and better education of providers concerning their obligation to protect their provider number(s) from unauthorized use and the need to notify

² Additional information about provider enrollment and application vulnerabilities can be found in *Independent Physiological Laboratories: Vulnerabilities Confronting Medicare* (OEI-05-97-00240) and *Independent Physiological Laboratories: Carrier Perspectives* (OEI-05-97-00241).

Medicaid when their employment relationships with clinics and other providers terminates.

Evidence suggest that many physicians do not adequately protect their provider numbers. Some States acknowledge that unscrupulous persons have circumvented their provider enrollment safeguards by:

- ▶ stealing a legitimate provider's billing number,
- ▶ purchasing the billing number of a legitimate provider, and,
- ▶ establishing themselves as a billing company.

According to Florida and Texas, some physicians are totally unaware that billing number information they have shared with former and potential employers has been used to defraud Medicaid. Other physicians knowingly sell their provider numbers to non physician providers. These physicians, many of whom are retired, accept payments for the use of their credentials. In an effort to stop misuse of physician provider numbers, the State of Florida visits all physicians who meet certain criteria that suggest the physician may be no longer be in active medical practice. Better provider number termination policies and periodic contacts with physicians to verify that provider information is current would improve safeguards.³

Strengthen Federal and State laws to hold physicians and other Medicaid providers financially and criminally liable for reckless conduct for participating in any deception that allows others to use their credentials and business to defraud or cause financial harm to Medicaid program.

Medicaid funds obtained through fraud and deception are often paid to a third party. Our past studies, and this study, have shown that third parties obtain the assistance of physicians and other providers to facilitate the perpetration of fraud against government programs.⁴ We believe that government programs need to address this vulnerability in their system safeguards stemming from physicians who permit others to use their identity to circumvent program safeguards or who permit the use of their professional licenses and places of business as a front to deceive Medicaid. Physicians found to be in reckless disregard of such a law should face criminal, civil and administrative actions.

Identify and register all clearinghouses and third-party billers and improve safeguards to ensure that electronic claims are accepted only from authorized sites and terminals.

Unscrupulous persons can circumvent enrollment safeguards by operating a billing service and offering trial periods and other incentives to obtain a physician's billing

³ Additional information about provider enrollment and application vulnerabilities can be found in *Independent Physiological Laboratories: Vulnerabilities Confronting Medicare* (OEI-05-97-00240), *Independent Physiological Laboratories: Carrier Perspectives* (OEI-05-97-00241) and *Medical Billing Software and Processes Used to Prepare Claims* (OEI-05-99-00100).

⁴ Ibid.

number. Once a legitimate provider number is known, a billing agency can misuse it. Today's Medicaid systems do not ensure that claims originating from billing agencies have been properly authorized by the physician under whose name claims are submitted. Most Medicaid programs cannot identify billing companies that submit claims nor can they determine which physicians use which billing companies.⁵

Centralize responsibility for, and improve, employee fraud and abuse awareness training.

With some exceptions, it appears that Medicaid staff (and subcontracted staff) training about fraud and abuse may be too fragmented to be effective. Staff training about fraud and abuse is often left to the different State components (pharmacy, long-term care, dental, etc.) and not the responsibility of any single centralized agency.⁶

All of the States we visited have an internal unit to conduct reviews and research allegations of wrong doing. These units provide an opportunity for improving staff awareness about fraud and abuse. States should consider using these units to improve employee awareness of their responsibility to help identify and combat fraud and abuse. Moreover, improving the visibility of these units can provide States with an opportunity to streamline and clarify fraud and abuse reporting processes and help reduce the likelihood that allegations of fraud and abuse would be inappropriately handled.

Patient advocates, case managers, second medical/dental opinions and certificates of medical necessity also provide additional opportunities for improving Medicaid safeguards. States with patient advocates help patients make informed medical decisions, provide treatment and care alternatives and reduce the number of medically unnecessary procedures. States that subcontract with specialists to provide second opinions appear to have been successful in curbing abuse of certain procedures. An opportunity exists to improve State second opinion programs. Second opinions from independent parties help control questionable medical procedures. They can also be used as a deterrent to prevent overutilization of services requiring a certificate of medical necessity. Random second opinions may provide an opportunity for improving safeguards to protect Medicaid programs against forged and inaccurate certificates of medical necessity.

AGENCY COMMENTS

We received comments on this report from HCFA. The HCFA believes that the opportunities for improvement described in this report provide valuable information that will be shared with the State Medicaid programs. The full text of HCFA's comments can be found in Appendix A.

⁵ Additional information about billing companies and system vulnerabilities can be found in *Medical Billing Software and Processes Used to Prepare Claims*. OEI-05-99-00100.

⁶ Additional information about fragmented responsibilities for the handling fraud and abuse issues can be found in *Carrier Fraud Units*. OEI-05-94-00470.

APPENDIX A

HCFA Comments on this Report



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JUN 15 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle *Nancy-Ann DeParle*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Payment Safeguards: Proactive Safeguards, Claims Processing Safeguards, and Post Payment Safeguards," (OEI-05-99-00070, OEI-05-99-00071, and OEI-05-99-00072)

The Health Care Financing Administration (HCFA) would like to thank the OIG for allowing us the opportunity to review the above-mentioned reports.

Since 1993, the Clinton Administration has done more than any previous administration to fight fraud, waste, and abuse in the Medicare and Medicaid programs. The result is a record series of investigations, indictments, and convictions, as well as new management tools to identify improper payments to health care providers. Last year, the federal government recovered more than \$500 million as a result of health care prosecutions.

HCFA has helped fight the battle of Medicaid fraud, waste, and abuse by partnering with States, beneficiaries, providers, contractors, and other federal agencies. The States themselves, are primarily responsible for detecting, prosecuting, and preventing Medicaid fraud, waste, and abuse. HCFA provides funding and technical assistance, and oversees States in their efforts to ensure that taxpayer dollars are spent appropriately. We also provide States with comprehensive guidance and technical support so they can strengthen efforts to prevent improper payments rather than try to recoup them after the fact. HCFA has been working with States to help them develop better data systems and other technological tools for ferreting out fraud, waste, and abuse. We are modifying our National Fraud Investigation Database to include Medicaid cases which will further help in tracking down and stopping unscrupulous providers across the country.

The focus of the National Medicaid Fraud and Abuse Initiative, has been to combat fraud and abuse in partnership with the States. We are also working to help States develop more proactive safeguard measures. The National Initiative was established in June 1997 and we have accomplished many things over the past three (3) years

Specifically, in August, 1997 we conducted a focus group session with States soliciting ideas for preventing fraud and abuse. As a result, we have :

- ◆ Worked with our State partners to develop a Medicaid Fraud and Abuse Control Technical Advisory Group (TAG);
- ◆ Established a Medicaid Fraud Statutes Website which contains a comprehensive database of state program integrity provisions;
- ◆ Developed draft Guidelines for Addressing Fraud and Abuse in Managed Care; and
- ◆ Developed a draft Medicaid Managed Care Compliance Plan which will soon be made available to States.

In our National Medicaid Fraud and Abuse initiative we maximize collaboration and communication among States and Federal Agencies. This involves:

- ◆ Working with your office, the Department of Justice, the Medicaid Fraud Control Units and Program Integrity Units in their role of prosecuting fraudulent providers,
- ◆ Ensuring that all States are aware of fraudulent activities and scams occurring nationwide,
- ◆ Promoting consistency by developing national guidelines;

However, we agree that more needs to be done, and we are committed to repeating and building upon the success across the country. The OIG should be aware that HCFA is exploring the feasibility of measuring Medicaid payment error rates on a State-specific and national basis. The purpose of such an initiative would be to measure and ultimately reduce Medicaid payment errors.

We believe the "Opportunities for Improvements" described in each report provided us with valuable information. As we mentioned at the March 9, 2000 exit conference with the OIG, we applaud the presentation of their suggestions as "opportunities." We believe States will view most of these "opportunities" as constructive and when the OIG releases these three reports in final form, we will ask our regional offices to share them with their States.